FOR OHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0014076

Facility Name: Sunny Hill Skilled Rehab Ctr

Address: 421 Doris Avenue (Number) Joliet (City) 60433 (Zip Code)

County: Will

Telephone Number: (815) 727-8710 **Fax #** (815) 727-8637

IDPA ID Number: 366006672001

Date of Initial License for Current Owners: 1955

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY	X	GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership	X	County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact
Name: Christine A. Hanover **Telephone Number:** (312) 634-4581
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/01/2004 to 11/30/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title)
(Firm Name & Address) Altschuler, Melvoin and Glasser LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 384-6000 Fax # (312) 634-5518

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/2004 Ending: 11/30/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	100	Skilled (SNF)	100	36,500	1
2		Skilled Pediatric (SNF/PED)			2
3	200	Intermediate (ICF)	200	73,000	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	300	TOTALS	300	109,500	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,818	1,076	6,062	9,956	8
9	SNF/PED					9
10	ICF	49,523	10,762	6,663	66,948	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	52,341	11,838	12,725	76,904	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.23%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location
Date started 1972

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date N/A NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 50 and days of care provided 6,062

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year YES [X] NO [ ]

Tax Year: No tax year Fiscal Year: 11/30/2005

* All facilities other than governmental must report on the accrual basi

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 **Report Period Beginning:** 12/01/2004 **Ending:** 11/30/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	753,347		14,760	768,107		768,107		768,107			1
2	Food Purchase		477,055		477,055		477,055	(1,696)	475,359			2
3	Housekeeping	777,789	85,267		863,056		863,056		863,056			3
4	Laundry	206,754		27,117	233,871		233,871		233,871			4
5	Heat and Other Utilities			262,493	262,493		262,493		262,493			5
6	Maintenance		809	99,330	100,139		100,139	521,586	621,725			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,737,890	563,131	403,700	2,704,721		2,704,721	519,890	3,224,611			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	5,915,116	414,129	396,216	6,725,461		6,725,461		6,725,461			10
10a	Therapy		16,525	543,908	560,433		560,433		560,433			10a
11	Activities	244,727			244,727		244,727		244,727			11
12	Social Services	249,892			249,892		249,892		249,892			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	6,409,735	430,654	940,124	7,780,513		7,780,513		7,780,513			16
	C. General Administration											
17	Administrative	112,934			112,934		112,934		112,934			17
18	Directors Fees											18
19	Professional Services			68,897	68,897		68,897	899,408	968,305			19
20	Dues, Fees, Subscriptions & Promotion			33,846	33,846		33,846	(195)	33,651			20
21	Clerical & General Office Expense	382,604	12,017	39,517	434,138		434,138	52,025	486,163			21
22	Employee Benefits & Payroll Taxe			109,407	109,407		109,407	3,613,171	3,722,578			22
23	Inservice Training & Educatior			1,767	1,767		1,767		1,767			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportatio			1,386	1,386		1,386		1,386			25
26	Insurance-Prop.Liab.Malpractice							261,856	261,856			26
27	Other (specify):*											27
28	**TOTAL General Administration**	495,538	12,017	254,820	762,375		762,375	4,826,265	5,588,640			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	8,643,163	1,005,802	1,598,644	11,247,609		11,247,609	5,346,155	16,593,764			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.** SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr #0014076 Report Period Beginning: 12/01/2004 Ending: 11/30/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			292,773	292,773		292,773		292,773			30
31	Amortization of Pre-Op. & Org											31
32	Interest			99	99		99	(99)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			82,413	82,413		82,413		82,413			35
36	Other (specify):*											36
37	**TOTAL Ownership**			375,285	375,285		375,285	(99)	375,186			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		233,234		233,234		233,234		233,234			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			164,250	164,250		164,250		164,250			42
43	Other (specify):* **lab, x-ray**			19,867	19,867		19,867	(19,867)				43
44	**TOTAL Special Cost Centers**		233,234	184,117	417,351		417,351	(19,867)	397,484			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	8,643,163	1,239,036	2,158,046	12,040,245		12,040,245	5,326,189	17,366,434			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See Schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/2004 Ending: 11/30/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Program				3
4	Non-Patient Meals	(1,696)	2		4
5	Telephone, TV & Radio in Resident Room				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(99)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainer				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(14,622)	21		28
29	Other-Attach Schedule See Attached Schedule 5A	(21,659)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (38,076)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	5,364,265		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 5,364,265		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 5,326,189		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Sunny Hill Skilled Rehab Ctr
Provider #: 0014076
12/1/2004 to 11/30/2005 **Schedule 5A**

VI. Adjustment Detail
Line 29 - Other

Non-allowable expenses	Amount	Reference
Chamber of Commerce dues	(195)	20
Out of Period Legal Fees	(1,597)	19
Lab Services	(6,936)	43
Radiology Services	(12,931)	43
Total	(21,659)	

SEE ACCOUNTANTS' COMPILATION REPORT

Sunny Hill Skilled Rehab Ctr

ID# 0014076

Report Period Beginning: 12/01/2004

Ending: 11/30/2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Misc. - Part A	$		1
2	Labs - Part A			2
3	X-Rays - Part A			3
4	Vending Machine Expense			4
5	Disallowed Non-Care Related Real Estate Tax			5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 **Report Period Beginning:** 12/01/2004 **Ending:** 11/30/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,696)	0	0	0	0	0	0	0	0	0	0	(1,696)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	521,586	0	0	0	0	0	0	0	0	0	521,586	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,696)	521,586	0	0	0	0	0	0	0	0	0	519,890	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	901,005	0	0	0	0	0	0	0	0	0	901,005	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(14,622)	66,647	0	0	0	0	0	0	0	0	0	52,025	21
22	Employee Benefits & Payroll Taxes	0	3,613,171	0	0	0	0	0	0	0	0	0	3,613,171	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	261,856	0	0	0	0	0	0	0	0	0	261,856	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(14,622)	4,842,679	0	0	0	0	0	0	0	0	0	4,828,057	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(16,318)	5,364,265	0	0	0	0	0	0	0	0	0	5,347,947	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 **Report Period Beginning:** 12/01/2004 **Ending:** 11/30/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense / D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(99)	0	0	0	0	0	0	0	0	0	0	(99)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(99)	0	0	0	0	0	0	0	0	0	0	(99)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(16,417)	5,364,265	0	0	0	0	0	0	0	0	0	5,347,848	45

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/2004 Ending: 11/30/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Will County	100%	N/A		Will County	Joliet	Government

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Professional services	$	Will County	100.00%	$ 901,005	$ 901,005	1
2	V	21	Film processing		Will County	100.00%	23,757	23,757	2
3	V	22	Employee benefits		Will County	100.00%	3,613,171	3,613,171	3
4	V	26	Insurance		Will County	100.00%	261,856	261,856	4
5	V	6	Maintenance		Will County	100.00%	521,586	521,586	5
6	V	21	Telephone		Will County	100.00%	42,890	42,890	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$ 5,364,265	$ * 5,364,265	14

* Total must agree with the amount recorded on line 34 of Schedule VI

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/2004 Ending: 11/30/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/2004 Ending: 11/30/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4	See attached list of	County board									4
5	board members	member	Administrative	0.00	None	<1 hour	0.00	N/A	None	N/A	5
6	No services have been provided to the nursing home by board member										6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/2004 Ending: 1/30/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central offic or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets

Name of Related Organization: Will County
Street Address: 302 North Chicago
City / State / Zip Code: Joliet, IL 60432
Phone Number: (815) 740-4607
Fax Number: (815) 740-4319

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	Maintenance	Direct cost	N/A	1	$ 521,586	$	1	$ 521,586	1
2	19	Professional services	Number of warrants	N/A	1	901,005		1	901,005	2
3	21	Film processing	Estimated time	N/A	1	23,757		1	23,757	3
4	22	Employee benefits	Direct cost	N/A	1	3,613,171		1	3,613,171	4
5	21	Telephone	Direct cost	N/A	1	42,890		1	42,890	5
6	26	Insurance	Direct cost	N/A	1	261,856		1	261,856	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,364,265	$		$ 5,364,265	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/2004 Ending: 11/30/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7	Various		X	Finance charges							99	7
8												8
9	TOTAL Facility Related						$	$			$ 99	9
	B. Non-Facility Related*											
10												10
11								Less: non-allowable finance charges			(99)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (99)	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7 (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr **#** 0014076 **Report Period Beginning:** 12/01/2004 **Ending:** 11/30/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and l must accompany the cost report	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ N/A	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2000	8
	2001	9
	2002	10
	2003	11
	2004	12

Not applicable - county does not pay real estate taxes.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sunny Hill Skilled Rehab Ctr COUNTY Will

FACILITY IDPH LICENSE NUMBER 0014076

CONTACT PERSON REGARDING THIS REPORT Karen Sobero, Administrator

TELEPHONE (815) 727-8710 FAX #: (815) 727-8637

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	N/A - county does not pay real estate taxes		$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/2004 Ending: 11/30/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 128,067 B. General Construction Type: Exterior Brick Frame Steel, concrete block Number of Stories Two

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization [X] (c) Rent equipment from Completely Unrelated Organization

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's groun (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, et List entity name, type of business, square footage, and number of beds/units available (where applicable

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortize [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident care		1972	$ 25,000	1
2					2
3	TOTALS			$ 25,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/2004 Ending: 11/30/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	150		1972	1972	$ 1,375,843	$ 34,396	40	$ 34,396	$	$ 1,163,730	4
5	150		1976	1976	1,198,083	29,952	40	29,952		883,584	5
6											6
7											7
8											8
	Improvement Type**										
9	Fencing			1970	727		20			727	9
10	Landscaping			1972	51,575		10-20			51,575	10
11	Patching and Paving/Air Conditioning/Entrance			1973	37,155		10-20			37,155	11
12	Door			1974	38,466		20			38,466	12
13	Asphalt Paving			1975	155,856		15			155,856	13
14	Landscaping			1976	57,254		10-15			57,254	14
15	Sewer and Water			1976	26,031	868	30	868		25,606	15
16	Plumbing			1972	183,817		25			183,817	16
17	Heating and Electrical			1972	522,443		20			522,443	17
18	Plumbing			1976	262,534		25			262,534	18
19	Heating and Electrical			1976	508,942		20			508,942	19
20	Sprinkler System and Paving			1975	83,460		25			83,460	20
21	Repairs / Roof			1981	107,858		15			107,858	21
22	Building Improvement			1987	819,813	32,792	25	32,792		606,654	22
23	Reroof A & B Roof			1985	85,920	1,518	20	1,518		85,290	23
24	Parking Lot Lights			1989	3,040		15			3,040	24
25	Reroof / Hot Water			1992	162,867	8,143	20	8,143		109,931	25
26	Washer Repair			1992	3,284		3			3,284	26
27	Site Improvements			1993	101,451	6,764	15	6,764		84,550	27
28	Laundry Renovation			1994	108,852	7,256	15	7,256		83,444	28
29	Paving Parking Lot			1995	66,260	4,417	15	4,417		46,378	29
30	Laundry, Air Conditioner			1996	362,815	30,235	12	30,235		287,232	30
31	Elevator Repair			1997	4,990	499	10	499		4,242	31
32	Tile			1992	7,040		5			7,040	32
33	Elevator Repair			1996	2,212		3			2,212	33
34	Sheeting			1993	3,685		3			3,685	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/2004 Ending: 11/30/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Site improvement	1998	$ 2,936	$ 294	10	$ 294	$	$ 2,205	37
38	Electrical work	1998	2,085	209	10	209		1,567	38
39	Plumbing repair	1998	2,440	244	10	244		1,830	39
40	Boiler repair	1998	4,273	427	10	427		3,203	40
41	Fence	1999	1,000	100	10	100		650	41
42	Air Conditioning Repair	1999	6,284	628	10	628		4,082	42
43	Boiler repair	1999	4,965	497	10	497		3,230	43
44	Doors	1999	4,842	484	10	484		3,146	44
45	Carpeting	1999	1,649	165	10	165		1,072	45
46	Nurses Station	1999	53,554	5,355	10	5,355		33,469	46
47	Wallpaper	2000	840	84	10	84		462	47
48	Vinyl Board	2000	823	82	10	82		451	48
49	Office Compressor	2000	1,205	120	10	120		660	49
50	Fire System	2000	3,441	344	10	344		1,892	50
51	Fence	2000	936	94	10	94		517	51
52	Air Ducts	2000	3,090	309	10	309		1,700	52
53	Service Work	2000	1,573	157	10	157		864	53
54	Parking Lot	2000	4,860	486	10	486		2,673	54
55	Circular Pumps	2000	1,079	108	10	108		594	55
56	Boiler repair	2001	5,326	533	10	533		2,398	56
57									57
58	Plumbing	2002	11,756	1,176	10	1,176		4,116	58
59	Air Cleaner	2002	2,020	202	10	202		707	59
60	Boiler	2002	5,658	567	10	567		1,984	60
61	HVAC Control	2002	2,800	280	10	280		980	61
62	Fire and Smoke Dampers	2002	26,087	2,609	10	2,609		9,131	62
63	Doors	2002	4,155	416	10	416		1,456	63
64	Fireproof Framing	2002	2,730	273	10	273		956	64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 6,504,680	$ 173,083		$ 173,083	$	$ 5,495,984	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/2004 Ending: 11/30/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dolla

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forwarc		$ 6,504,680	$ 173,083		$ 173,083	$	$ 5,495,984	1
2	HVAC	2003	11,370	1,137	10	1,137		2,843	2
3	Plumbing	2003	11,833	1,183	10	1,183		2,958	3
4	Oven repairs	2003	3,020	302	10	302		755	4
5	Dishwasher repairs	2003	1,419	142	10	142		355	5
6	Garbage disposal	2003	2,429	243	10	243		607	6
7	Freezer doors	2003	5,610	561	10	561		1,403	7
8	Boiler repairs	2003	21,892	2,189	10	2,189		5,473	8
9	Entrance door repairs	2003	13,240	1,324	10	1,324		3,310	9
10	Washing machine repai	2003	1,045	105	10	105		262	10
11	Site improvement	2003	8,252	825	10	825		2,063	11
12									12
13	Fire alarm system	2004	140,676	14,068	10	14,068		21,102	13
14	Water pipes replaced	2004	44,498	4,450	10	4,450		6,675	14
15	Structural work	2004	5,331	534	10	534		801	15
16	Windows	2004	29,590	2,960	10	2,960		4,440	16
17	Wall divider	2004	11,280	1,128	10	1,128		1,692	17
18	Front gate and posts	2004	8,025	802	10	802		1,203	18
19									19
20	Various lighting	2005	60,791	3,040	10	3,040		3,040	20
21	Cabinet	2005	1,200	60	10	60		60	21
22	Cabinet	2005	4,900	245	10	245		245	22
23	Pavement	2005	6,581	329	10	329		329	23
24	Stump removal and excavatio	2005	12,600	630	10	630		630	24
25	Fire alarm modificatior	2005	4,286	214	10	214		214	25
26	Iron fence	2005	23,365	1,168	10	1,168		1,168	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,937,913	$ 210,722		$ 210,722	$	$ 5,557,612	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Numbe Sunny Hill Skilled Rehab Ct # 0014076 Report Period Beginning: 12/01/2004 Ending: 11/30/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instruction

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 52,852	$ 5,286	$ 5,286	$	10	$ 7,929	71
72	Current Year Purchases	102,822	5,141	5,141		10	5,141	72
73	Fully Depreciated Assets	2,003,986	71,624	71,624		10	2,003,986	73
74								74
75	TOTALS	$ 2,159,660	$ 82,051	$ 82,051	$		$ 2,017,056	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77	N/A									77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Asset

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 9,122,573	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 292,773	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 292,773	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 7,574,668	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progres

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

SEE ACCOUNTANTS' COMPILATION REPORT

** This must agree with Schedule V line 30, column (

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/2004 Ending: 11/30/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease N/A .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 82,413 Description: See attached schedule 14a
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Sunny Hill Nursing Home
PROVIDER # 0014076
11/30/2005

Schedule 14a

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Helium Tanks	
Mattress rental	10,933
IV Pump	2,136
Respiratory therapy equipment	20,946
Ice Machine	2,580
Dish Machine	3,479
Resident lift	24,814
Other medical equipment	17,525
	82,413

See Accountants' Compilation Report

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/2004 Ending: 11/30/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [ ] YES [X] NO

It is the policy of this facility to only hire certified nurses aides

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits
(c) For in-house training programs only. Do not include fringe benefits
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10A,C.3	hrs	$	4,943	$ 231,357	$	4,943	$ 231,357	1
2	Licensed Speech and Language Development Therapist	L10A,C.3	hrs		1,731	80,993		1,731	80,993	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A,C.3	hrs		4,203	196,683		4,203	196,683	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39,C.2	# of prescrpts				233,234		233,234	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Respiratory therapy	L10A,C.3,C.2			1,012	30,355	16,525	1,012	46,880	13
14	TOTAL			$	11,889	$ 539,388	$ 249,759	11,889	$ 789,147	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be lis on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr **#** 0014076 **Report Period Beginning:** 12/01/2004 **Ending:** 11/30/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 11/30/2005 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)			3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	25,000	25,000	13
14	Buildings, at Historical Cost	6,444,148	6,444,148	14
15	Leasehold Improvements, at Historical Cost	493,765	493,765	15
16	Equipment, at Historical Cost	2,148,781	2,159,660	16
17	Accumulated Depreciation (book methods)	(7,574,668)	(7,574,668)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,537,026	$ 1,547,905	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,537,026	$ 1,547,905	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 16,790	$ 16,790	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	894,238	894,238	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 911,028	$ 911,028	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 911,028	$ 911,028	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 625,998	$ 636,877	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,537,026	$ 1,547,905	48

SEE ACCOUNTANTS' COMPILATION REPORT ***(See instructions.)**

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/2004 Ending: 11/30/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 758,860	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 758,860	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,270,085)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,270,085)	17
	B. Transfers (Itemize):		
18	**Interfund transfers**	1,137,223	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 1,137,223	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 625,998	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/2004 Ending: 11/30/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Car	$ 10,769,978	1
2	Discounts and Allowances for all Level	182	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,770,160	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Educatior		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radic		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patient		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income**		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,770,160	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,704,721	31
32	Health Care	7,780,513	32
33	General Administratior	762,375	33
	B. Capital Expense		
34	Ownership	375,285	34
	C. Ancillary Expense		
35	Special Cost Centers	253,101	35
36	Provider Participation Fee	164,250	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,040,245	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,270,085)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,270,085)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/2004 Ending: 11/30/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,696	2,080	$ 76,020	$ 36.55	1
2	Assistant Director of Nursing	1,960	2,080	59,134	28.43	2
3	Registered Nurses	33,032	35,941	920,449	25.61	3
4	Licensed Practical Nurses	64,138	68,289	1,411,541	20.67	4
5	CNAs & Orderlies	229,017	246,990	3,162,447	12.80	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	12,851	14,560	285,525	19.61	8
9	Activity Director	1,996	2,080	46,509	22.36	9
10	Activity Assistants	14,512	15,677	198,218	12.64	10
11	Social Service Worker	9,767	10,438	249,892	23.94	11
12	Dietician					12
13	Food Service Supervisor	7,508	8,320	174,138	20.93	13
14	Head Cook					14
15	Cook Helpers/Assistants	49,860	52,993	579,209	10.93	15
16	Dishwashers					16
17	Maintenance Worker					17
18	Housekeepers	59,180	65,669	777,789	11.84	18
19	Laundry	15,732	17,456	206,754	11.84	19
20	Administrator	1,877	2,080	77,334	37.18	20
21	Assistant Administrator	1,346	1,346	35,600	26.45	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	18,176	21,409	382,604	17.87	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	522,648	567,408	$ 8,643,163 *	$ 15.23	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	369	$ 14,760	L1, C3	35
36	Medical Director				36
37	Medical Records Consultant	34	1,540	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	16,447	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultan				41
42	Respiratory Therapy Consultan				42
43	Speech Therapy Consultant	90	4,520	L10A, C3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	Alzheimers	49	2,910	L10, C3	47
48					48
49	TOTAL (lines 35 - 48)	542	$ 40,177		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	2,076	$ 98,718	L10, C3	50
51	Licensed Practical Nurses	4,187	163,292	L10, C3	51
52	Certified Nurse Assistants/Aides	5,188	113,309	L10, C3	52
53	TOTAL (lines 50 - 52)	11,451	$ 375,319		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number: Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/2004 Ending: 11/30/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Karen Sobero	Administrator	0	$ 77,334
Becky Halderson	Asst. Administrator	0	35,600
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.			$ 112,934

B. Administrative - Other

Description	Amount
	$
N/A	
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Duane Morris LLP	Legal	$ 10,022
UHC/Accumed Systems	Computer	3,295
Health Data Systems In	Computer	12,814
Altschuler Melvoin&Glasser, LLP	Accounting	10,000
American Express Tax & Bus Svce	Accounting	15,779
RSM McGladrey	Accounting	2,533
Medworks Hlth Services	Drug Screening	9,146
Mediworks	Medical Billing	249
Medifax-EDI, Inc	Medical Billing	82
Joliet Fed. Of Musicians	Music	1,615
Mutual of Omaha	Medicare Billing	2,626
See attached Schedule 21a		736
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 68,897

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 333,620
Unemployment Compensation Insurance	
FICA Taxes	672,787
Employee Health Insurance	1,869,075
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	783,347
Uniforms	63,749
TOTAL (agree to Schedule V, line 22, col.8)	$ 3,722,578

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	8,337
Health Care Worker Background Check	
(Indicate # of checks performed 147)	1,767
County Nursing Home Assn dues	2,220
Illinois Health Care Assn	13,057
Dues and subscriptions	7,430
MW Automated Time System license	1,035
Less: Public Relations Expense	(195)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 33,651

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Sunny Hill Skilled Rehab Ctr
Provider #: 0014076
12/01/2004 to 11/30/2005 **Schedule 21A**

XIX. SUPPORT SCHEDULE
C. Professional Services

Subtotal		68,161
WCS/Joliet	Medical billing	736
Total (agree to Schedule V, line 19, column 3)		68,897
Allocated from Will County		901,005
Disallow out of period Duane Morris fees		(1,597)
Total (agree to Schedule V, line 19, column 8)		968,305

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/2004 Ending: 11/30/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7	N/A												
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union **Yes**

(2) Are there any dues to nursing home associations included on the cost repor **Yes**
If YES, give association name and amount **IHCA $13,057; County NH Assn $ 2,220**

(3) Did the nursing home make political contributions or payments to a politic action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at th end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases **Yes**
What was the average life used for new equipment added during this perioc **10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expens and the location of this expense on Sch. V. $ **156,147** Line **L10, C2**

(7) Have all costs reported on this form been determined using accounting procedur consistent with prior reports? **Yes** If NO, attach a complete explanation

(8) Are you presently operating under a sale and leaseback arrangemen **No**
If YES, give effective date of lease **N/A**

(9) Are you presently operating under a sublease agreemen ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions f Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility IDPH license number of this related party and the date the present owners took ove
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmer during this cost report period. $ **164,250**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule for an individual employee? **No** If YES, attach an explanation of the allocation

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed t the Department, in addition to the daily rate, been properly classifie in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services f the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attac a schedule which explains how all related costs were allocated to these function

(15) Indicate the cost of employee meals that has been reclassified to employee benefi on Schedule V. $ **N/A** Has any meal income been offset agains related costs? **Yes** Indicate the amount $ **1,696**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel **No**
If YES, attach a complete explanation
b. Do you have a separate contract with the Department to provide medical transportation fc residents? **No** If YES, please indicate the amount of income earned from such program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients **0**
d. Have vehicle usage logs been maintained **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all oth times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjust out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm **Yes**
Firm Name: **Wermer, Rodgers, Daran & Ryan** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this cop been attached? **No** If no, please explain **Audit is not complete**

(18) Have all costs which do not relate to the provision of long term care been adjusted o out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of servic performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fee

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	753,347	0	14,760	768,107	0	768,107	0	768,107
2. Food Purchase	0	477,055	0	477,055	0	477,055	-1,696	475,359
3. Housekeeping	777,789	85,267	0	863,056	0	863,056	0	863,056
4. Laundry	206,754	0	27,117	233,871	0	233,871	0	233,871
5. Heat and Other Utilities	0	0	262,493	262,493	0	262,493	0	262,493
6. Maintenance	0	809	99,330	100,139	0	100,139	521,586	621,725
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	1,737,890	563,131	403,700	2,704,721	0	2,704,721	519,890	3,224,611
9. Medical Director	0	0	0	0	0	0	0	0
10. Nursing & Medical Records	5,915,116	414,129	396,216	6,725,461	0	6,725,461	0	6,725,461
10a. Therapy	0	16,525	543,908	560,433	0	560,433	0	560,433
11. Activities	244,727	0	0	244,727	0	244,727	0	244,727
12. Social Services	249,892	0	0	249,892	0	249,892	0	249,892
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	6,409,735	430,654	940,124	7,780,513	0	7,780,513	0	7,780,513
17. Administrative	112,934	0	0	112,934	0	112,934	0	112,934
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	68,897	68,897	0	68,897	899,408	968,305
20. Fees, Subscriptions & Promotion	0	0	33,846	33,846	0	33,846	-195	33,651
21. Clerical & General Office	382,604	12,017	39,517	434,138	0	434,138	52,025	486,163
22. Employee Benefits & Payroll	0	0	109,407	109,407	0	109,407	3,613,171	3,722,578
23. Inservice Training & Education	0	0	1,767	1,767	0	1,767	0	1,767
24. Travel and Seminar	0	0	0	0	0	0	0	0
25. Other Admin. Staff Trans	0	0	1,386	1,386	0	1,386	0	1,386
26. Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	261,856	261,856
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	495,538	12,017	254,820	762,375	0	762,375	4,826,265	5,588,640
29. Total General Administrative	8,643,163	1,005,802	1,598,644	11,247,609	0	11,247,609	5,346,155	16,593,764
30. Depreciation	0	0	292,773	292,773	0	292,773	0	292,773
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	99	99	0	99	-99	0
33. Real Estate	0	0	0	0	0	0	0	0
34. Rent - Facility & Grounds	0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles	0	0	82,413	82,413	0	82,413	0	82,413
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	375,285	375,285	0	375,285	-99	375,186
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	233,234	0	233,234	0	233,234	0	233,234
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	164,250	164,250	0	164,250	0	164,250
43. Other (specify):*	0	0	19,867	19,867	0	19,867	-19,867	0
44. Total Special Cost Ce	0	233,234	184,117	417,351	0	417,351	-19,867	397,484
45. Grand Total	8,643,163	1,239,036	2,158,046	12,040,245	0	12,040,245	5,326,189	17,366,434

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	0	0
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	0	0
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	0	0
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	0	0
10. Total current assets	0	0
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	25,000	25,000
14. Buildings, at Historical Cost	6,444,148	6,444,148
15. Leasehold Improvements, Historical Cost	493,765	493,765
16. Equipment, at Historical Cost	2,148,781	2,159,660
17. Accumulated Depreciation (book methods)	-7,574,668	-7,574,668
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	1,537,026	1,547,905
25. Total Assets	1,537,026	1,547,905
CURRENT LIABILITIES		
26. Accounts Payable	16,790	16,790
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	894,238	894,238
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	0	0
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	911,028	911,028
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	0
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	0	0
46.Total Liabilities	911,028	911,028
47.Total Equity	625,998	636,877
48.Total Liabilities and Equity	1,537,026	1,547,905

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	10,769,978
2. Discounts and Allowances for all Levels	182
Subtotal - Inpatient Care	10,770,160
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	0
7. Oxygen	0
Subtotal - Anciliary Revenue	-
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	0
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiologyand X-Ray	0
21. Other Medical Services	0
22. Laundry	0
Subtotal - Other Operating Revenue	-
24. Contributions	0
25. Interest and Other Investments Income	0
Subtotal - Non-Operating Revenue	-
27. Other Revenue (specify):	0
28. Other Revenue (specify):	0
Subtotal - Other Revenue	-
30. Total Revenue	10,770,160
31. General Services	2,704,721
32. Health Care	7,780,513
33. General Administration	762,375
34. Ownership	375,285
35. Special Cost Centers	253,101
35. Provider Participation Fee	164,250
37. Other	0
40. Total Expenses	12,040,245
41. Income Before Income Taxes	-1,270,085
42. Income Taxes	0
43. Net Income or Loss for the Year	-1,270,085